PEDIATRIC TRAVEL VACCINES

- MEERA VARMAN MD
- PROFESSOR
- PEDIATRIC INFECTIOUS DISEASES
- CREIGHTON UNIVERSITY

NO CONFLICT OF INTEREST

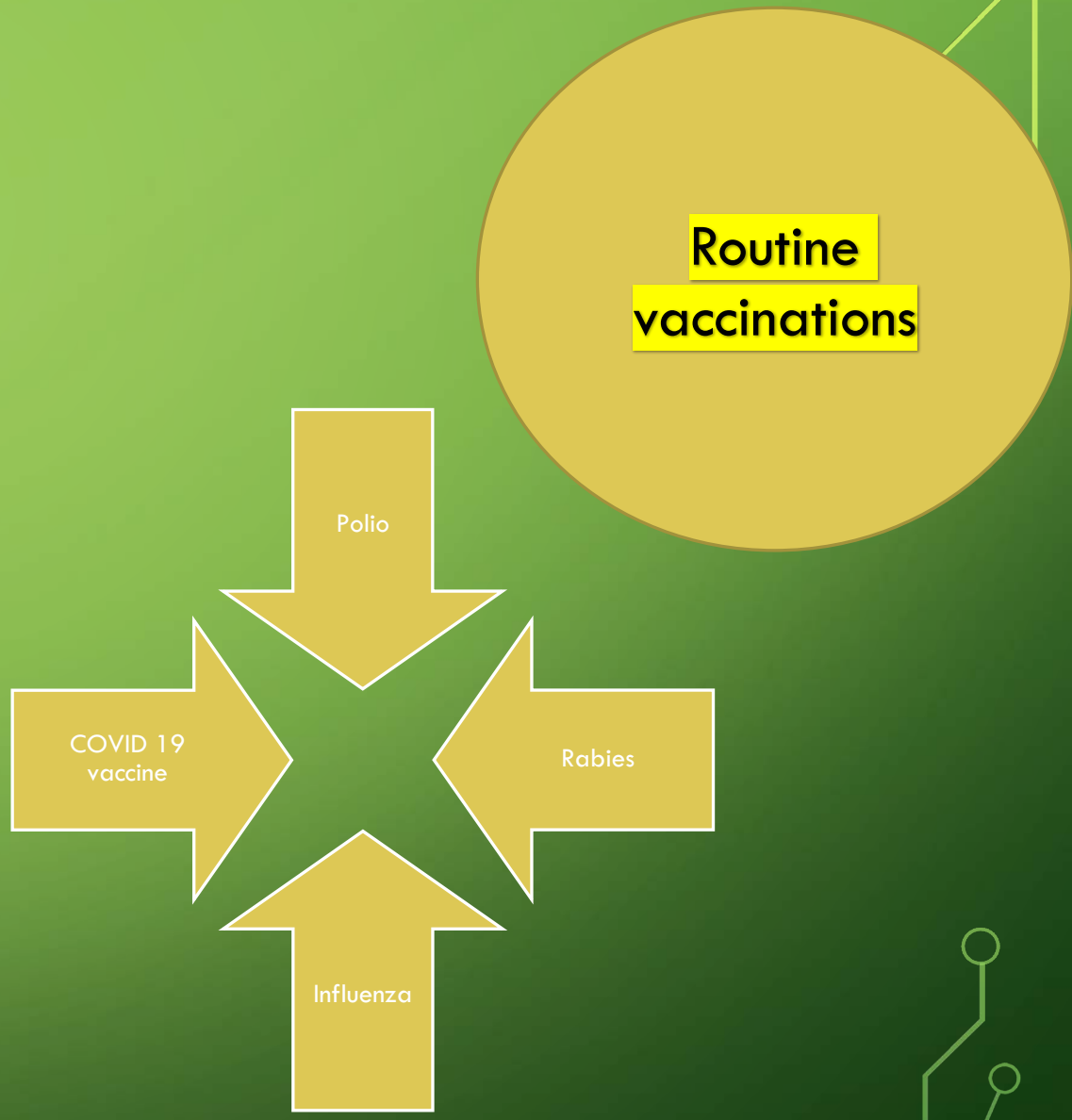
- Mental and physical health
- Creativity
- Mind sharp
- Reduce stress
- Shifts perspective

OBJECTIVES

- To understand the recommended Pediatric travel vaccines
- To understand the required Pediatric travel vaccines per CDC
- Other travel precautions and resources

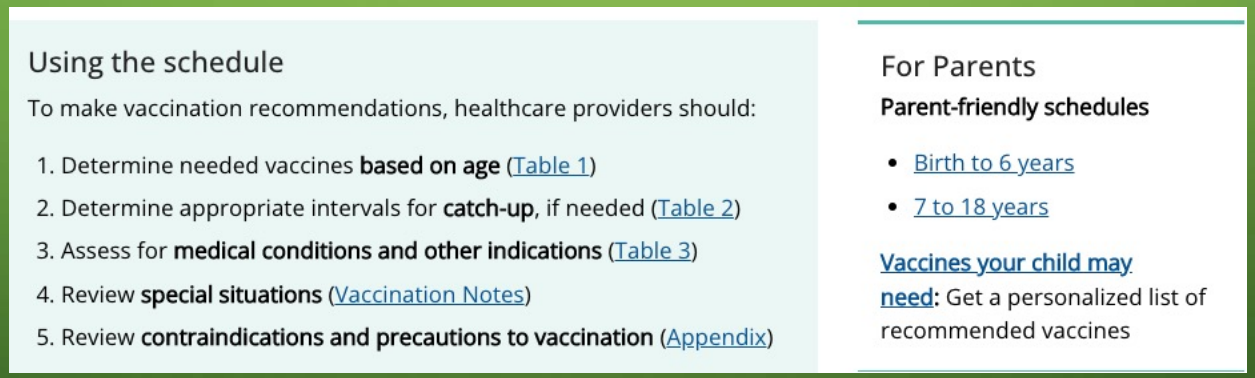
TRAVEL VACCINES

- Typhoid
- Japanese encephalitis
- Yellow fever
- MMR
- Hepatitis A
- Hepatitis B
- Meningococcal



ROUTINE VACCINATION

- https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#birth-15
- CDC schedule based on ACIP recommendations



Using the schedule

To make vaccination recommendations, healthcare providers should:

1. Determine needed vaccines **based on age** (Table 1)
2. Determine appropriate intervals for **catch-up**, if needed (Table 2)
3. Assess for **medical conditions and other indications** (Table 3)
4. Review **special situations** (Vaccination Notes)
5. Review **contraindications and precautions to vaccination** (Appendix)

For Parents

Parent-friendly schedules

- Birth to 6 years
- 7 to 18 years

Vaccines your child may need: Get a personalized list of recommended vaccines

TYPHOID

- Epidemiology
- Clinical
- Prevention
- Vaccines
- Doses-single, 2 weeks before
- Precaution

20 million cases of typhoid

5 million cases of paratyphoid annual-worldwide

Headache, malaise, and anorexia are nearly universal, and abdominal pain, diarrhea, or constipation are common. Vomiting and diarrhea are more common in children

Case fatality. 10-30%

TYPHOID VACCINES

- Two unconjugated typhoid vaccines are licensed and available in the United States:
- Vi capsular polysaccharide vaccine (ViCPS) (Typhim Vi, manufactured by Sanofi Pasteur) for intramuscular use
- Oral live attenuated vaccine (Vivotif, manufactured from the Ty21a strain of serotype Typhi by Emergent BioSolutions)

Typhim IM –Every 2 years
Ty21 a oral-Every 5 years

Table 4-22. Vaccines to prevent typhoid fever

VACCINA-TION	AGE (y)	DOSE, MODE OF ADMINISTRA-TION	NUMBER OF DOSES	DOSING INTERVAL	BOOSTING INTERVAL
Oral, Live, Attenuated Ty21a Vaccine (Vivotif)[1]					
Primary series	≥6	1 capsule,[2] oral	4	48 hours	Not applicable
Booster	≥6	1 capsule,[2] oral	4	48 hours	Every 5 years
Vi Capsular Polysaccharide Vaccine (Typhim Vi)					
Primary series	≥2	0.50 mL, intramuscular	1	Not applicable	Not applicable
Booster	≥2	0.50 mL, intramuscular	1	Not applicable	Every 2 years

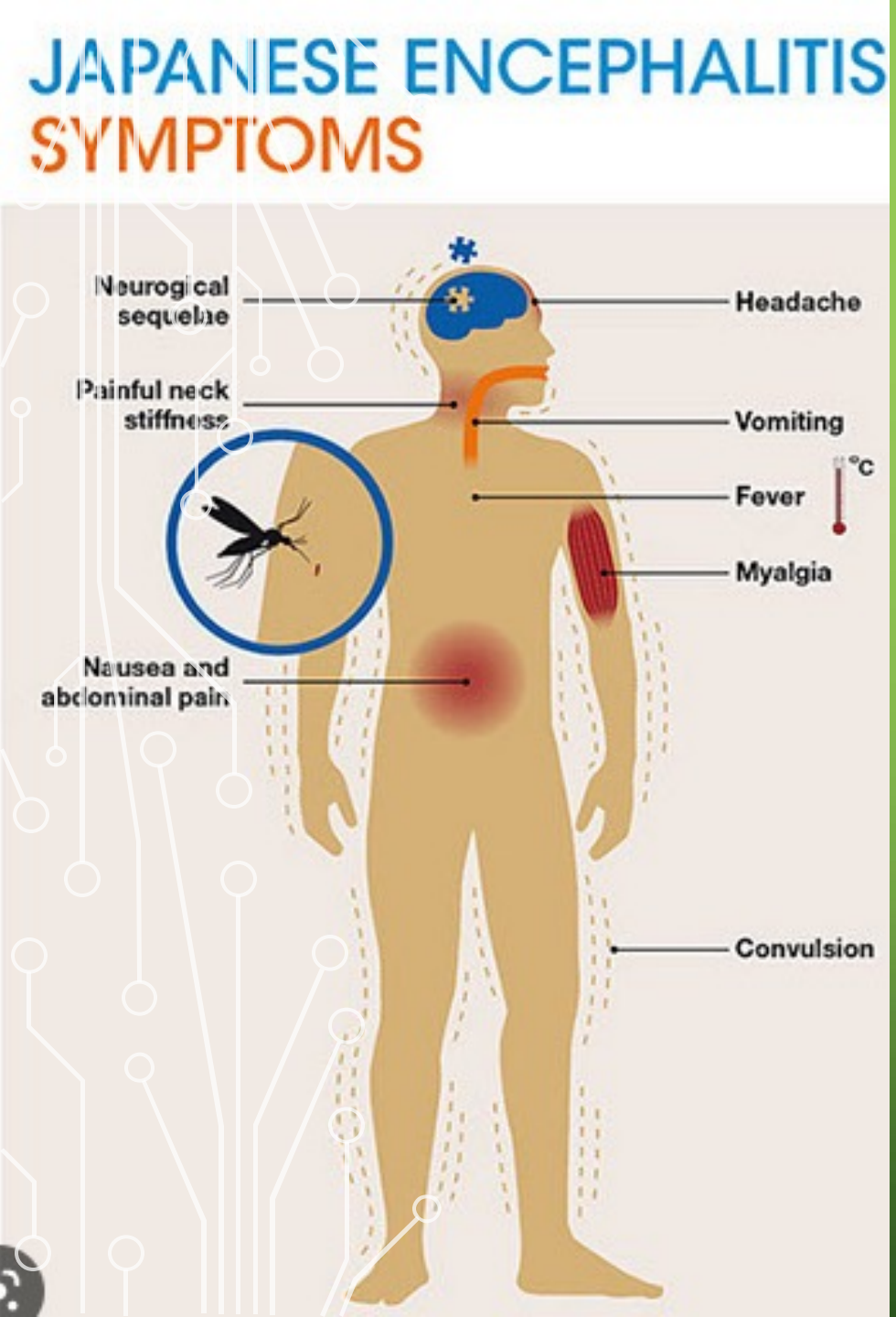
[1] The vaccine must be kept refrigerated (35.6°F–46.4°F, 2° C–8°C).
[2] Administer with cool liquid no warmer than 98.6°F (37°C).

TYPHOID VACCINE AE

- Pain from the vaccine, redness, or swelling at the site of the injection, fever, and headache, and general discomfort can happen after inactivated typhoid vaccine.
- Fever, headache, abdominal pain, diarrhea, nausea, and vomiting can happen after live typhoid vaccine.

JAPANESE ENCEPHALITIS RISK

- Location: Rural, Agriculture fields, Coastal, stagnant water
- Long term to endemic place
- Season –check CDC
- Activity: Outdoors
- Accomodations: Without Air condition, bed net



JAPANESE ENCEPHALITIS

- Epidemiology-culex mosquito, rural, >1 month
- Clinical -5-15 days incubation, sudden onset of fever, headache, and vomiting. Mental status changes, focal neurologic deficits, generalized weakness, and movement disorders may develop over the next few days. 20-30% fatal
- Season-summer and fall
- Vaccine
  - Doses-2 doses 28 days apart
  - 1 week prior to travel
  - 96-100% efficacy
- Prevention
  - repellent

https://www.travel-doc.com/service/japanese-encephalitis/
www.CDC.gov/travel

Table 4-06. Vaccine to prevent Japanese encephalitis (JE)

VACCINE	TRADE NAME (MANU-FACTURER)	AGE	DOSE	ROUTE	SCHEDULE	BOOSTER[1]
JE vaccine, inactivated	Ixiaro (Valneva)	2 mo–2 y	0.25 mL	IM	0, 28 d	≥1 y after primary series
		3–17 y	0.5 mL	IM	0, 28 d	≥1 y after primary series
		18–65 y	0.5 mL	IM	0, 7–28 d	≥1 y after primary series
		>65 y	0.5 mL	IM	0, 28 d	≥1 y after primary series

Abbreviation: IM, intramuscular

YELLOW FEVER

- Epidemiology-mosquito, primarily *Aedes* or *Haemagogus* spp.
- Clinical
- Requirement
- Transit passengers
- Doses –single
- Documentation-Yellow card
- Adverse events
- Contra Indications

Table 4-23. Countries with risk of yellow fever (YF) virus transmission[1]

AFRICA			CENTRAL AND SOUTH AMERICA
Angola	Ethiopia[2]	Nigeria	Argentina[2]
Benin	Gabon	Senegal	Bolivia[2]
Burkina Faso	The Gambia	Sierra Leone	Brazil[2]
Cameroon	Ghana	South Sudan	Colombia[2]
Central African Republic	Guinea	Sudan[2]	Ecuador[2]
Chad[2]	Guinea-Bissau	Togo	French Guiana
Congo, Republic of the	Kenya[2]	Uganda	Guyana
Côte d'Ivoire	Liberia		Panama[2]
Democratic Republic of the Congo[2]	Mali[2]		Paraguay
Equatorial Guinea	Mauritania[2]		Peru[2]
	Niger[2]		Suriname
			Trinidad and Tobago[2]
			Venezuela[2]

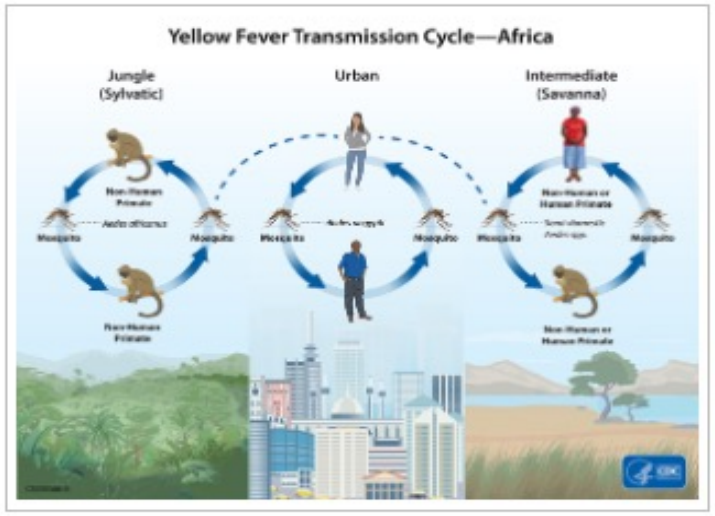
[1] Defined by the World Health Organization as countries or areas where YF "has been reported currently or in the past and vectors and animal reservoirs currently exist." See current Annex 1 and country list on the WHO *International Travel and Health* webpage at www.who.int/ith/en/index.html).

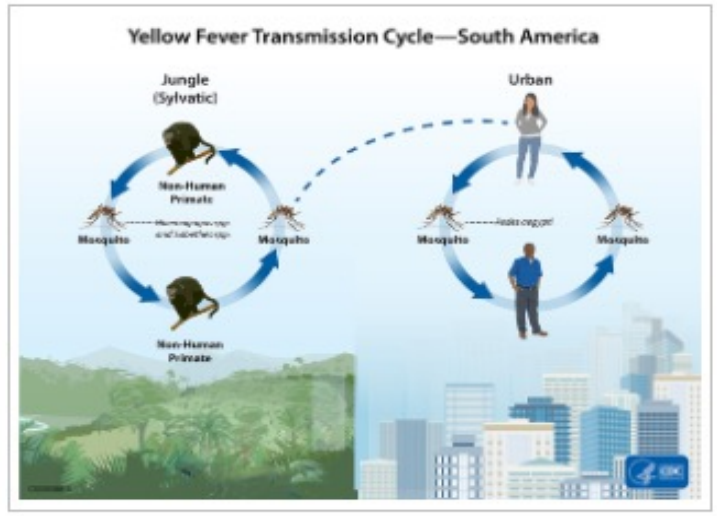
[2] These countries are not holoendemic (only a portion of the country has risk of YF virus + transmission). See Maps 4-13 and 4-14 and yellow fever vaccine recommendations (Yellow Fever & Malaria Information, by Country) for details.

YELLOW FEVER –

Initial symptoms can include sudden onset of fever, chills, severe headache, back pain, general body aches, nausea, vomiting, fatigue (feeling tired), weakness.

- 1/7 develop severe symptoms
- Severe symptoms include high fever jaundice, bleeding, shock, and organ failure.
- Among those who develop severe disease, 30-60% die.





Aedes Mosquito
Flavi virus

YELLOW FEVER SEASON

- South America
  Highest during the rainy season (January–May
- peak incidence in February and March).

Rural West Africa is seasonal,

Elevated risk

- The end of the rainy season
- Beginning of the dry season (usually July–October).


JAMAICA
Kingston
GUADELOUPE
MARTINIQUE
BARBADOS
CURAÇAO
NICARAGUA
Santa Marta
Caracas
Port-of-Spain
TRINIDAD
San José
Cartagena
Maturin
Panama City
VENEZUELA
Georgetown
PANAMA
Medellin
GUYANA
Paramaribo
Bogotá
SURINAME
Cayenne
COLOMBIA
FRENCH GUIANA
Cali
Quito
ECUADOR
Riobamba
Puyo
Manaus
Iquitos
Fortaleza
PERU
Chachapoyas
BRAZIL
Recife
Huánuco
Aracaju
Lima
Salvador
Cusco
BOLIVIA
Brasília
La Paz
Sucre
Santa Cruz
Belo Horizonte
Tarija
PARAGUAY
CHILE
Rio de Janeiro
São Paulo
Salta
Asunción
Resistencia
Porto Alegre
ARGENTINA
Santiago
URUGUAY
Buenos Aires
Montevideo
FALKLAND ISLANDS
Yellow Fever Vaccine
Vaccination recommended
Vaccination recommended since 2017 due to yellow fever outbreak[2]
Vaccination generally not recommended[3]
Vaccination not recommended

Map 4-13. Yellow fever vaccine recommendations in Africa[1]

Table 4-25. Vaccine to prevent yellow fever (YF)

VACCINE	TRADE NAME (MANU-FACTURER)	AGE	DOSE	ROUTE	SCHEDULE	BOOSTER
17D	YF-Vax (Sanofi Pasteur)	≥9 months [1]	0.5 mL [2]	SC	1 dose	Not recommended for most [3]

Abbreviation: SC, subcutaneous.

[1] Ages 6–8 months and ≥60 years are precautions and age <6 months is a contraindication to the use of YF vaccine.

[2] YF-Vax is available in single-dose and multiple-dose (5-dose) vials.

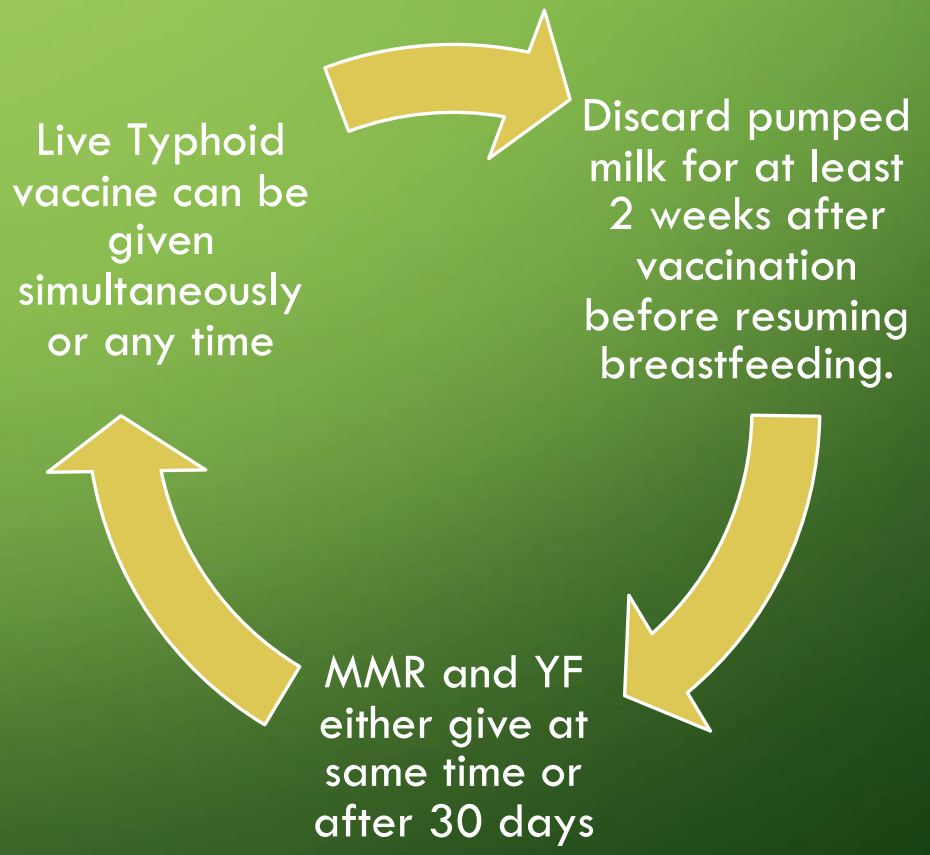
[3] For further details regarding revaccination, see "Vaccine Administration" in this section.

Table 4-26. Contraindications and precautions to yellow fever vaccine administration

CONTRAINDICATIONS	PRECAUTIONS
• Allergy to vaccine component[1] • Age <6 months • Symptomatic HIV infection or CD4 T-lymphocytes <200/mm^3 (or <15% of total in children aged <6 years)[2] • Thymus disorder associated with abnormal immune-cell function • Primary immunodeficiencies • Malignant neoplasms • Transplantation • Immunosuppressive and immunomodulatory therapies	• Age 6–8 months • Age ≥60 years • Asymptomatic HIV infection and CD4 T-lymphocytes 200–499/mm^3 (or 15%–24% of total in children aged <6 years)[2] • Pregnancy • Breastfeeding

YF VACCINE

- International certificate of vaccination or prophylaxis is stamped and given. (ICVP)



YELLOW FEVER VACCINATION

95% VE in 10 days

- Adverse effect
- injection site pain, inflammation, mild headaches, myalgia, low-grade fever, backache, or other minor symptoms that occur 2–11 days post-vaccination.

- Serious adverse effect
- Vaccine-associated neurotropic disease (YEL-AND)-encephalitis
- Vaccine-associated viscerotropic disease (YEL-AVD)-multiorgan failure

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6386100/

MMR

- Outbreaks
- Hesitancy-in some communities
- Clinical-prodrome, Koplik spots, rash
- Routine 2 doses
- 6 -11 month 1 dose
  - Complete 2 more doses

HEPATITIS A

- Epidemiology: Fecal oral route, infectious 1-2 weeks prior to symptoms , both developed and developing countries
- Clinical: Vomiting, abdominal pain, jaundice
- Routine vaccination >12 months
- Under 12 months of age
  - 6-11 months 1 dose
  - Complete 2 more doses
- Passive immunization

Adults aged >40 years, immunocompromised people, people with chronic liver disease, and people with other chronic medical conditions

- planning travel in <2 weeks may receive IG (0.1 mL/kg) in addition to vaccine at a separate injection site based on
- provider risk assessment, traveler's age, immune status and underlying conditions, risk of exposure, and availability of IG.

Accelerated 4-dose schedule is available for Twinrix; doses can be administered at 0, 7, and 21–30 days, followed by a dose at 12 months.

HEPATITIS B

- Epidemiology: Risk factors
  - poor infection control during medical or dental procedures, receipt of blood products, injection drug use, tattooing or acupuncture, and unprotected sex.
- Chronic HBV risk:
  - >90% of neonates and infants,
  - 25%–50% of children aged 1–5 years
  - <5% of older children and adults.

Routine vaccinations

Hepatitis B vaccine, recombinant[1]	Engerix-B (GlaxoSmithKline)	0–19 (primary)	0.5 mL (10 µg HBsAg)	IM	0, 1, 6 mo	None
		0–10 (accelerated)	0.5 mL (10 µg HBsAg)	IM	0, 1, 2 mo	12 mo
		11–19 (accelerated)	1.0 mL (20 µg HBsAg)	IM	0, 1, 2 mo	12 mo
		≥20 (primary)	1.0 mL (20 µg HBsAg)	IM	0, 1, 6 mo	None
		≥20 (accelerated)	1.0 mL (20 µg HBsAg)	IM	0, 1, 2 mo	12 mo
Hepatitis B vaccine, recombinant[1]	Recombivax HB (Merck & Co., Inc.)	0–19 (primary)	0.5 mL (5 µg HBsAg)	IM	0, 1, 6 mo	None
		11–15 (adolescent accelerated)	1.0 mL (10 µg HBsAg)	IM	0, 4–6 mo	None

Heplisav – recombinant >18

Twinrix Hep A HBV >18

INFLUENZA

Epidemiology:

- higher levels during colder winter months:
  - October to May in the Northern Hemisphere
  - April to September in the Southern Hemisphere.
  - In many tropical or subtropical regions, can occur throughout the year.

Avian influenza: H5N1 and other subtypes

- noted in poultry and wild birds

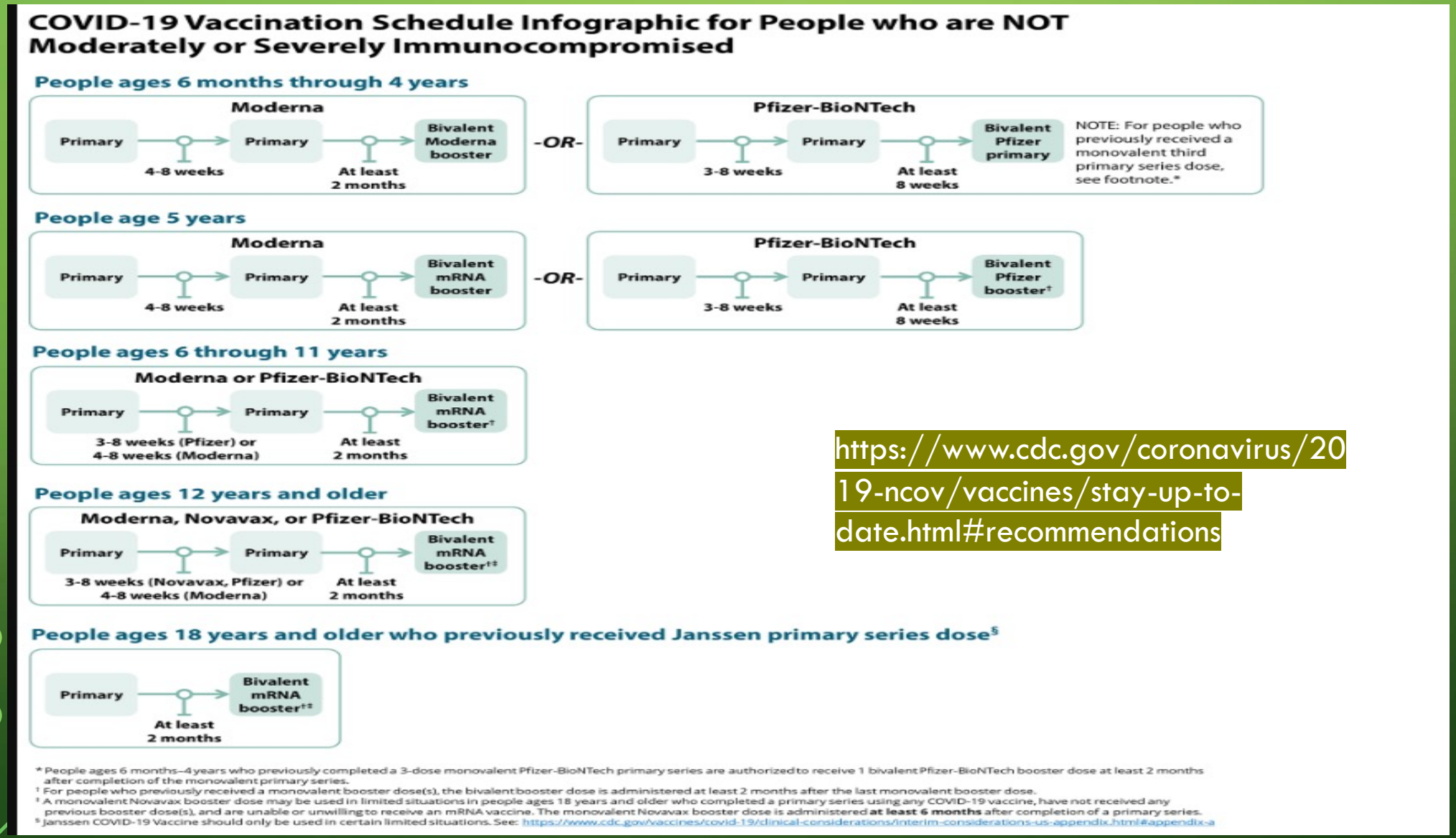
Seasonal influenza vaccine are not expected to protect against

- animal-origin influenza viruses, including avian influenza A(H5N1 and H7N9) viruses.

Annual immunization

- >6 months of age
- Infants 2 doses 1 month apart
- High risk patients

COVID 19 VACCINES



https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#recommendations

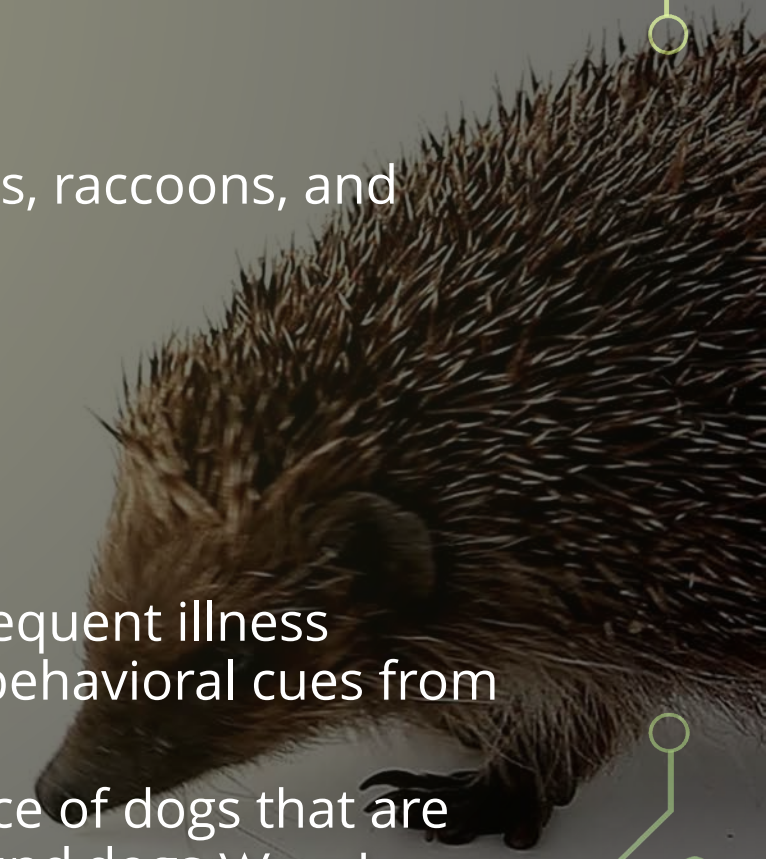
Table 2. COVID-19 vaccination schedule for people who are not moderately or severely immunocompromised

Age group	Number of primary series doses	Number of bivalent booster doses	Recommended bivalent booster dose*	Interval between 1st and 2nd primary series dose†	Interval between 2nd and 3rd primary series dose	Interval between primary series and booster dose‡
Moderna primary series						
6 months–4 years	2	1	Moderna	4–8 weeks	NA	At least 2 months
5 years	2	1	Moderna or Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
6–11 years	2	1	Moderna or Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
12 years and older	2	1	Moderna or Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
Novavax primary series						
12 years and older	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months

Age group	Number of primary series doses	Number of bivalent booster doses	Recommended bivalent booster dose*	Interval between 1st and 2nd primary series dose†	Interval between 2nd and 3rd primary series dose	Interval between primary series and booster dose‡
Pfizer-BioNTech primary series						
6 months–4 years	3 Currently authorized schedule: 1st and 2nd doses monovalent; 3rd dose bivalent	NA	NA	3–8 weeks	At least 8 weeks	NA
6 months–4 years	3 Previously authorized schedule: 3 monovalent doses§	1	Pfizer-BioNTech	3–8 weeks	At least 8 weeks	At least 2 months
5 years	2	1	Pfizer-BioNTech	3–8 weeks	NA	At least 2 months
6–11 years	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months
12 years and older	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months

RABIES

- Epidemiology:
  - dogs and wildlife, such as bats, foxes, jackals, mongooses, raccoons, and skunks
  - 16 to 200 per 100,000 travelers.
  - Animal handlers
  - Laboratory workers
- Avoiding animal Bites:
  - Children are at higher risk for rabies exposure and subsequent illness because of their inquisitive nature and inability to read behavioral cues from dogs and other animals.
  - avoidance of puppies when the mother is near, avoidance of dogs that are protecting a food source, and appropriate behavior around dogs.Wound care
- Wound care and Rabies vaccine/RIG



RABIES VACCINATION-PRE EXPOSURE PROPHYLAXIS

Table 4-17. Preexposure immunization for rabies[1]

VACCINE	DOSE (mL)	NUMBER OF DOSES	SCHEDULE (DAYS)[2]	ROUTE
HDCV, Imovax (Sanofi)	1.0	2	0 and 7	IM
PCEC, RabAvert (Novartis)	1.0	2	0 and 7	IM

Abbreviations: HDCV, human diploid cell vaccine; IM, intramuscular; PCEC, purified chick embryo cell.

[1] Patients who are immunosuppressed by disease or medications should postpone preexposure vaccinations and consider avoiding activities for which rabies preexposure prophylaxis is indicated during the period of expected immunosuppression. If this is not possible, immunosuppressed people who are at risk for rabies should have their antibody titers checked after vaccination.

[2] Every attempt should be made to adhere to recommended schedules; however, for most minor deviations (delays of a few days for individual doses), vaccination can be resumed as though the traveler were on schedule. If 2 doses of rabies vaccine cannot be completed before travel, the traveler should not start the series, as few data exist to guide PEP after a partial immunization series.

Table 4-18. Postexposure immunization for rabies[1]

IMMUNIZATION STATUS	VACCINE/ PRODUCT	DOSE	NUMBER OF DOSES	SCHEDULE (DAYS)[2]	ROUTE
Not previously vaccinated	RIG plus	20 IU/kg body weight	1	0	Infiltrated at bite site (if possible); remainder IM
Not previously vaccinated	HDCV or PCEC	1.0 mL	4[3]	0, 3, 7, 14 (28 if immuno-compromised[4])	IM
Previously vaccinated 5,6	HDCV or PCEC	1.0 mL	2	0, 3	IM

Abbreviations: RIG, rabies immune globulin; IM, intramuscular; HDCV, human diploid cell vaccine; PCEC, purified chick embryo cell.

[1] All postexposure prophylaxis should begin with immediate, thorough cleansing of all wounds with soap and water, povidone iodine, or other substances with virucidal activity.

[2] Every attempt should be made to adhere to recommended schedules; however, for most minor deviations (delays of a few days for individual doses), vaccination can be resumed as though the traveler were on schedule. When substantial deviations occur, immune status should be assessed by serologic testing 7–14 days after the final dose is administered.

[3] Five vaccine doses for the immunosuppressed patient. The first 4 vaccine doses are given on the same schedule as for an immunocompetent patient, and the fifth dose is given on day 28; patient follow-up should include monitoring antibody response. For more information, see www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm.

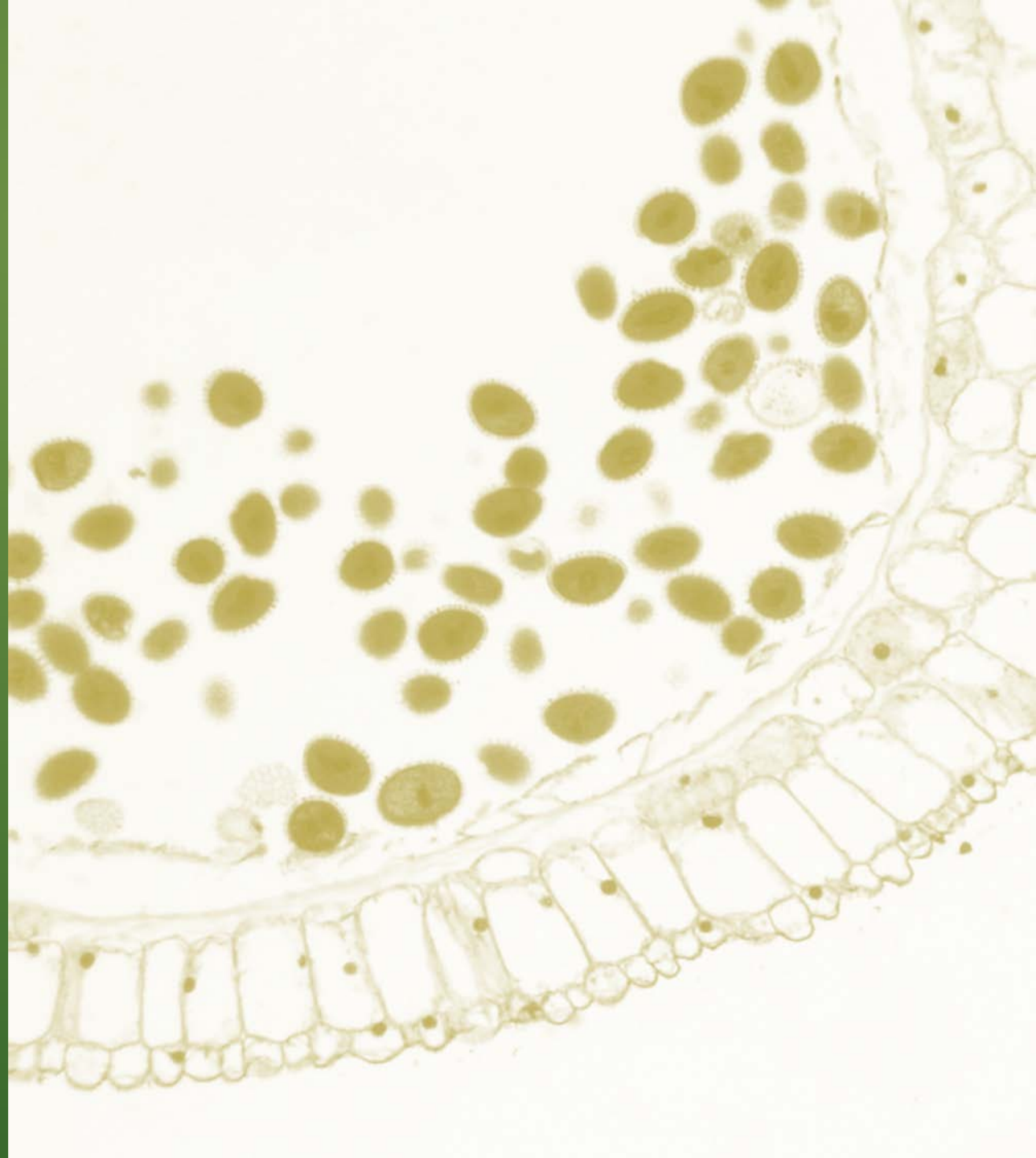
[4] CDC recommends 4 postexposure vaccine doses, on days 0, 3, 7, and 14, unless the patient is immunocompromised in some way, in which case a fifth dose is given at day 28.

[5] Preexposure immunization with HDCV or PCEC, prior postexposure prophylaxis with HDCV or PCEC, or people previously vaccinated with any other type of rabies vaccine and a documented history of positive rabies virus neutralizing antibody response to the prior vaccination.

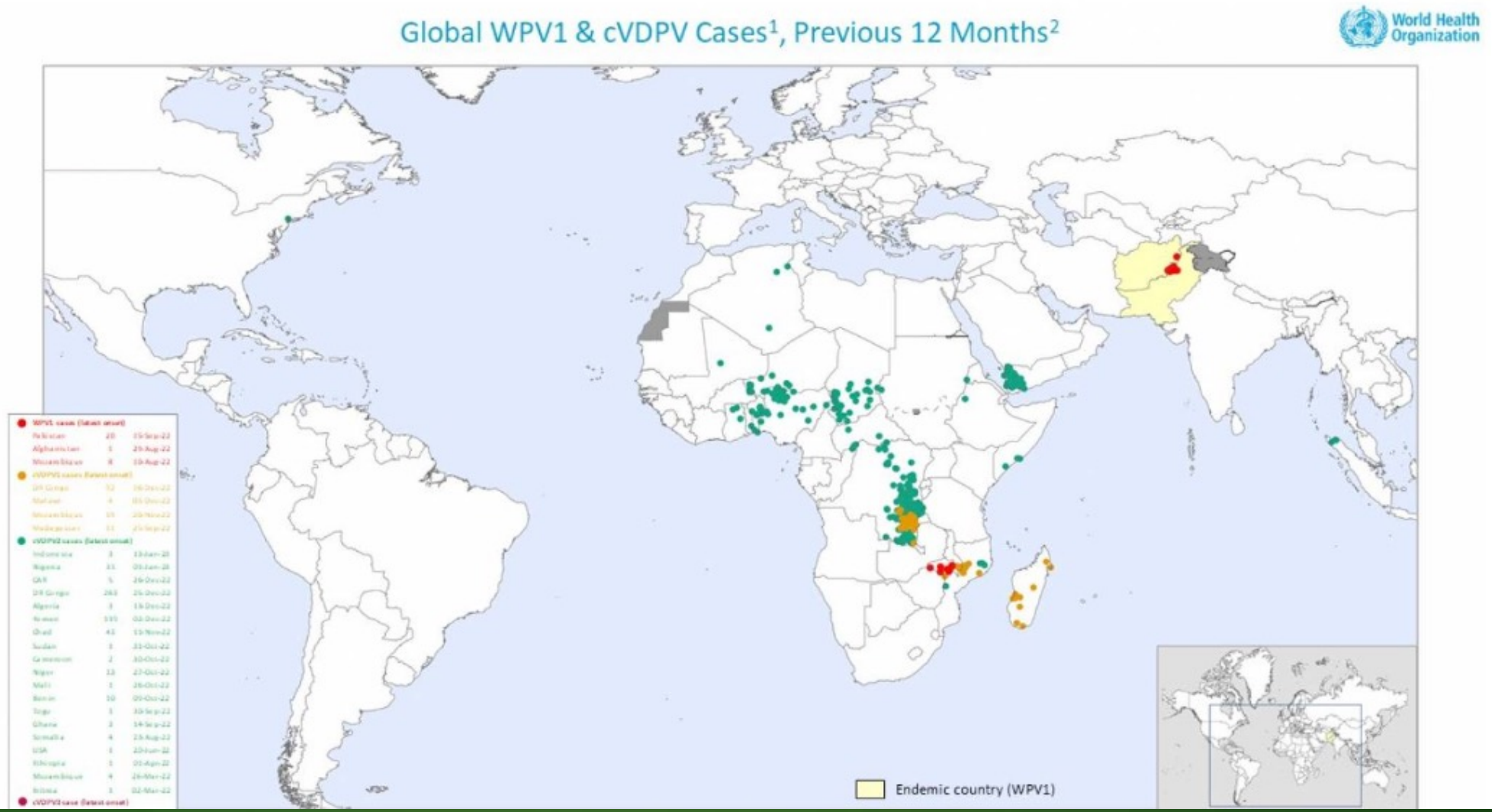
[6] RIG is not recommended.

POLIO

- Epidemiology: Throat and GI tract, shed 1-2 weeks in NP and 3-6 weeks in stool even in asymptomatic people
- Paralysis may affect 1 or several limbs,
- Severe cases it may result in quadriplegia, respiratory failure, and rarely, death.
- 20–30 years later worsening weakness or paralysis (postpolio syndrome).
- Adults with poliovirus paralysis have more severe disease and a worse prognosis than children.



Poliovirus spreads from people to people and is detected in wastewater



POLIO VACCINATION

Infants and children should receive 4 doses of IPV, at ages 2, 4, and 6–18 months and 4–6 years.

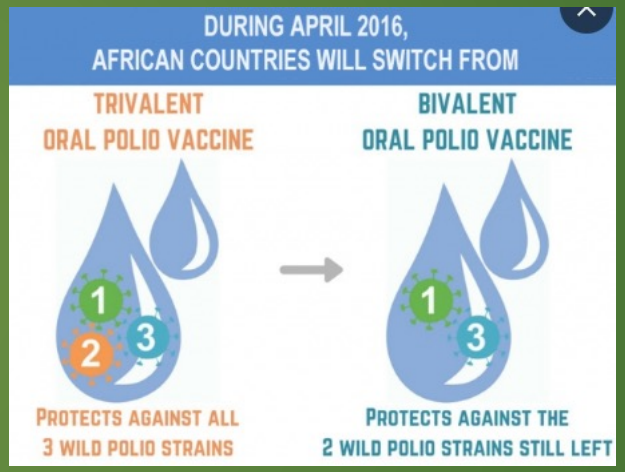
The final dose should be administered at age ≥4 years, regardless of the number of previous doses, and should be given ≥6 months after the previous dose.

A fourth dose in the routine IPV series is not necessary if the third dose was administered at age ≥4 years and ≥6 months after the previous dose.

IF NOT FULLY IMMUNIZED

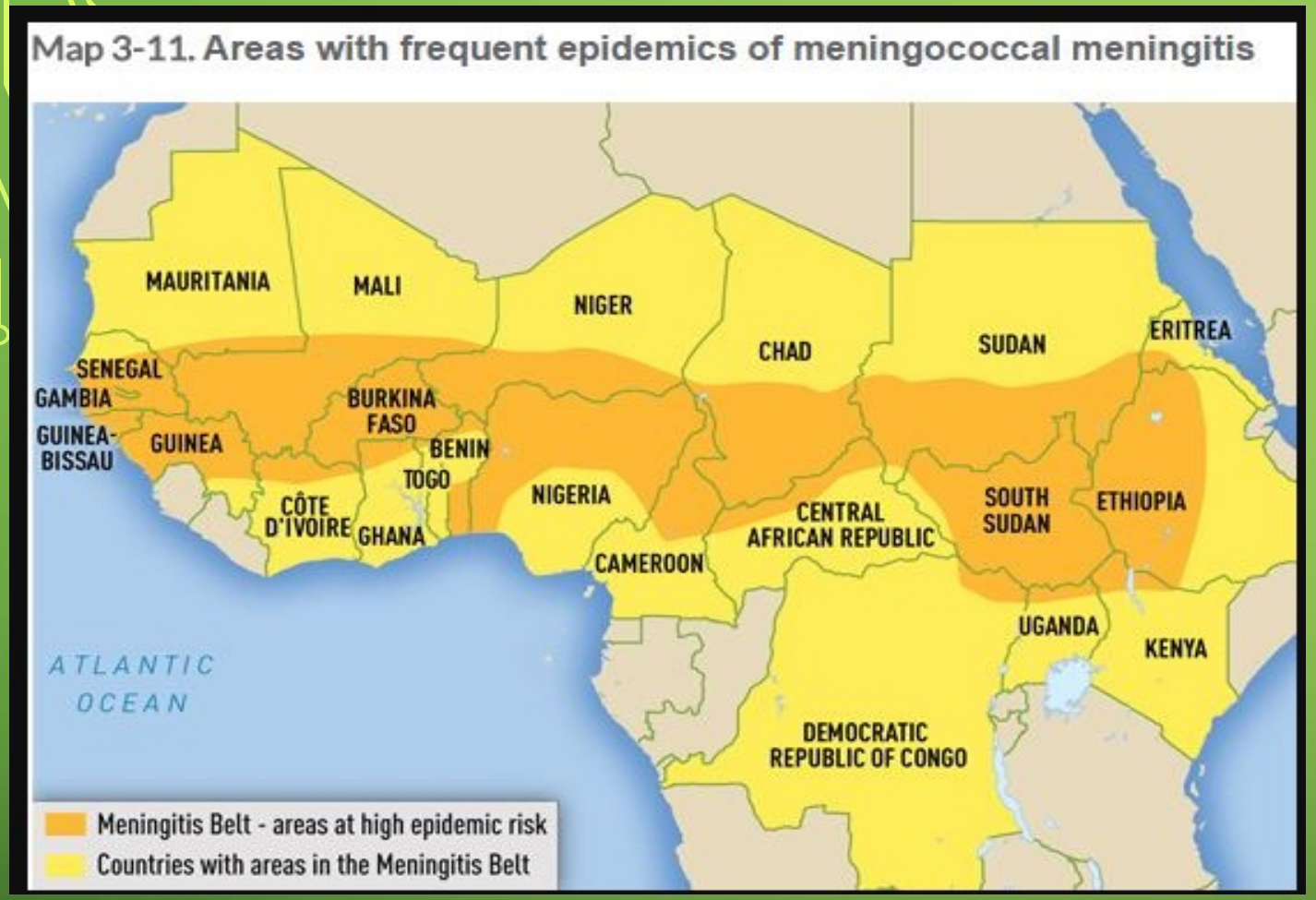
- The first dose should be given to infants at age ≥6 weeks.
- The second and third doses should be administered ≥4 weeks after the previous doses.
- The minimum interval between the third and fourth doses is 6 months.
- Breastfeeding is not a contraindication to administration of polio vaccine to an infant or mother

TOPV VS BOPV



Children with full vaccination status, who have only received bOPV in the primary series because they were born after April 2016, or a combination of tOPV and bOPV, should be revaccinated with a full IPV series to ensure protection against all 3 poliovirus types.

Children <18 years of age without adequate documentation of poliovirus vaccination should be vaccinated or revaccinated in accordance with the age-appropriate US IPV schedule.



- Epidemics in dry season
- Dec –June
- 1000/100,000
- Vaccine is recommended for travel to this high risk area

MENINGOCOCCAL VACCINE

Table 4-14. Meningococcal vaccines licensed and available in the United States

VACCINE	TRADE NAME (MANU-FACTURER)	AGE OF VACCINE INITIATION	DOSE	ROUTE	INTERVAL SINCE FIRST DOSE	BOOSTER
Meningococcal (serogroups A, C, W, and Y) oligosaccharide diphtheria CRM_{197} conjugate vaccine (MenACWY-CRM)[1]	Menveo (GSK)	2 mo	0.5 mL	IM	0, 2, 4, 10 mo	If at continued risk[3]
		7–23 mo	0.5 mL	IM	0, 3 mo (2nd dose administered in 2nd year of life)	
		≥2 y	0.5 mL	IM	1 dose[2]	
Meningococcal (serogroups A, C, W, and Y) polysaccharide diphtheria toxoid conjugate vaccine (MenACWY-D)[1]	Menactra (Sanofi Pasteur)	9–23 mo	0.5 mL	IM	0, 3 mo	If at continued risk[3]
		≥2 y	0.5 mL	IM	1 dose[2]	
Meningococcal serogroup B vaccine (MenB-FHbp)	Trumenba (Pfizer)	10–25 y	0.5 mL	IM	0, 1–2, 6 mo or 0, 6 mo (depending on indication)[4]	None
Meningococcal serogroup B vaccine (MenB-4C)	Bexsero (GSK)	10–25 y	0.5 mL	IM	0, ≥1 mo	None

Abbreviations: IM, intramuscular; SC, subcutaneous.

[1] If an infant is receiving the vaccine before travel, 2 doses may be administered as early as 8 weeks apart.

[2] For people with HIV, anatomic or functional asplenia, and people with persistent complement component deficiencies (C3, C5-9, properdin, factor D, and factor H or people taking eculizumab [Soliris]) should receive a 2-dose primary series 8–12 weeks apart.

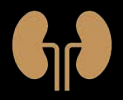
[3] Revaccination with meningococcal conjugate vaccine (MenACWY-D or MenACWY-CRM) is recommended after 3 years for children who received their last dose at <7 years of age. Revaccination with meningococcal conjugate vaccine is recommended after 5 years for people who received their last dose at ≥7 years of age, and every 5 years thereafter for people who are at continued risk.

[4] In April 2016, FDA approved updates to the prescribing information for MenB-FHbp to allow for the administration of either a 3-dose schedule (0, 1–2, 6 months) or a 2-dose schedule (0, 6 months). The 3-dose schedule is preferred for groups at increased risk where more rapid protection is desired.

MENINGOCOCCAL TRAVEL VACCINE

International travelers at risk for meningococcal disease who were previously vaccinated with a quadrivalent vaccine should receive a booster dose.

For children who completed the primary dose or series at <7 years of age, a booster dose of MenACWY should be administered after 3 years and repeated every 5 years thereafter if they live in or travel to a hyperendemic area.



For people who received the primary dose or series at ≥7 years of age, a booster dose should be administered after 5 years and every 5 years thereafter if they live in or travel to a hyperendemic area.

FOOD PRECAUTION

SAFE

- Bottled or canned drink
- Hot drink
- Pasteurized milk

AVOID

- TAP WATER
- ICE
- FRESH JUICE
- FOUNTAIN DRINK

Avoid raw food
Street food

TRAVELLER'S DIARRHEA

- Food precautions
- Imodium >12 years
- Hydration
- Hand hygiene
- E.coli –antibiotic resistance noted, Azithromycin

GENERAL SAFETY

- Vehicle-helmet, seat belt, no 2- wheeler
- Nighttime-avoid
- Water safety, drowning
- Insects –Mosquitoes and ticks—repellent
- Jet lag, Clotting, medications, altitudes
- Animals -avoid bites, snakes, monkeys and others

- 10-30% for infants and children
- Do not use under 2 months
- 100% DEET 12 hrs
- 2-34% lasts 3-6 hours
- CDC recommends 30-50%

"Protection against Mosquitoes, Ticks, Fleas and Other Insects and Arthropods". Travelers' Health – Yellow Book. Centers for Disease Control and Prevention. 2009-02-05.

CDC TRAVEL RESOURCE/DESTINATIONS

- WWW.cdc.gov/travel
- Yellow book-https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-related-infectious-diseases/
- Redbook 2021

Travelers' Health

Medical Tourism

Destinations

Where are you going?

-- Select One --

Go

YELLOW BOOK 2020

HEALTH INFORMATION FOR INTERNATIONAL TRAVEL

- "Once a year, go someplace you've never been before." – Dalai Lama

Thanks you!!